



ERNE FLETCHER
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
COMMISSIONER'S OFFICE
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JAMES W. HOLSINGER, JR., M.D.
SECRETARY

June 2, 2004

Hospital Provider Letter #A-205
Mental Hospital Provider Letter #A-81
Psychiatric Residential Treatment Facility Letter #A-122
ICF/MR/DD Provider Letter #A-337
Nursing Facility Letter #A-205

Dear Provider:

The Kentucky Department for Medicaid Services is proud to announce our new direct deposit system for Medicaid Provider payments. Direct deposit will guarantee the timely availability of funds and eliminate the possibility of lost payments, ensuring that providers receive payments faster and more efficiently.

Enclosed are the required form (MAP-811 Addendum E) and instructions for completion. You may also use this form at any time during the year to notify the Department of changes regarding the financial institution where your funds are to be deposited. This form is also available on line at www.kymmis.com.

Please complete this form and return it to us within sixty days. Direct deposit will begin in September of 2004. If you have any questions, please call Unisys Corporation at 877-838-5085. A provider enrollment specialist will be available to assist you between the hours of 8:00AM and 6:00PM, EST, Monday through Friday.

Sincerely,

Russ Fendley
Commissioner

**DEPARTMENT FOR MEDICAID SERVICES
DIRECT DEPOSIT AUTHORIZATION/CANCELLATION FORM**

Complete the following provider information:

Provider Number: _ _ _ _ _

Provider Name: _ _ _ _ _

Address: _ _ _ _ _

City: _ _ _ _ _ State: _ _ _ _ _ Zip: _ _ _ _ _

Telephone Number: _ _ _ - _ _ _ - _ _ _

Contact Name: _ _ _ _ _

☐ New Enrollment ☐ Institution or Account Change

Bank Name _ _ _ _ _

Branch or correspondent Bank (if applicable) _ _ _ _ _

City _ _ _ _ _ State: _ _ _ _ _ Zip: _ _ _ _ _

Transit/ABA Number: _ _ _ _ _

Account Number: _ _ _ _ _

Account Type (select one): ☐ Checking ☐ Savings

I, the undersigned, authorize the Department for Medicaid Services to initiate accounting transactions to deposit payments directly to the account indicated above. These deposits will pertain only to direct deposit payments for Medicaid services that the payee has rendered.

I understand that in the event that my account information should change, I must notify the Kentucky Medicaid agency immediately. I will not hold the Kentucky Medicaid agency liable for presentation of any or all direct deposits into the account indicated above if I fail to notify Kentucky Medicaid or the fiscal agent of my change in bank account information.

I understand that any false statements, documents; or concealment of a material fact, may be prosecuted under applicable federal or state laws.

Signature _ _ _ _ _

Title _ _ _ _ _ Date _ _ _ _ _

☐ Cancellation

I, the undersigned, hereby cancel the authorization for the Department for Medicaid Services to originate direct deposit entries into my checking/savings account. This cancellation is effective on date of receipt.

Signature: _ _ _ _ _

Title: _ _ _ _ _ Date: _ _ _ _ _

INSTRUCTIONS FOR DIRECT DEPOSIT AUTHORIZATION/CANCELLATION FORM

<u>FIELD NAME</u>	<u>FIELD INSTRUCTION</u>
Provider Number	The eight digit number assigned to the provider for services rendered to KY Medicaid recipients.
Provider Name	Enter the personal or business name.
Address	Enter the physical address.
City	Enter the physical city.
State	Enter the physical state.
Zip	Enter the physical zip code.
Telephone Number	Enter the telephone number where the provider can be reached during normal business hours.
Contact Name	Enter the name of the individual that can be contacted at the number indicated.
New Enrollment/Institution or Account Change	Indicate by marking the appropriate block if this form is for a new enrollment or a change to previous information.
Bank Name	Enter the name of the provider's financial institution.
Branch or Correspondent Bank	Enter branch name or major bank or the provider's financial institution, if applicable.
City, State, Zip	Enter physical city, state, and zip where the financial institution indicated above is located.
Transit/ABA Number	Enter the nine digit American Banking Association (ABA) identifying number for the financial institution indicated above. This number can be obtained from the institution or is normally the first nine digits of the electronic coding at the bottom of the check or deposit slip.
Account Number	Enter the provider's account number at the financial institution indicated above.
Account Type	Indicate by marking the appropriate block whether you would like the funds be deposited into checking or savings account.
Signature	Signature of provider or authorized representative of the provider.
Title	Title of the individual signing this form.
Date	Date this form is signed.
Cancellation Block	If you wish to cancel the direct deposit please mark the cancellation box and sign and date form.
Signature	Signature of provider or authorized representative of the provider.
Title	Title of the individual signing this form.
Date	Date this form is signed.

SUBMIT COMPLETED FORM TO:

Unisys Corporation
P.O. Box 2110
Frankfort, KY 40602
Telephone #: 800-838-5085